Here are my "Protocols for Nutrition Screening and Nutrition Case Management" as part of the array of nutrition services as related to Part B-Supportive Services and Senior Centers Sec. 321. (a)(1),(2),(5),(8),(17) *health and nutrition education services, including information concerning prevention, diagnosis, treatment, and rehabilitation of age-related diseases and chronic disabling conditions* and (19).

With clear guidance, I believe that it is possible to assure our seniors a full array of nutrition-related services, including Nutrition Case Management, by accessing some of these other resources to help with Medical Nutrition Therapy not funded under Medicare.

Entering The Nutrition Programs For Seniors

In accordance with Sec. 339.(2)(J) *provide nutrition screening and where appropriate, for nutrition education and counseling,* before a person receives any service under the Older Americans Act, the "NAPIS Information" and "Determine Your Nutritional Health Checklist" should be administered.

- **Step #1** "Determine Your Nutritional Health Checklist" results in a moderate to high risk of malnutrition. For example, this guidance could read: "A 3-5 score is considered moderate risk for malnutrition." The Nutrition Programs for Seniors shall provide information to seniors who are at risk for malnutrition on what can be done to improve their eating habits and lifestyle, and, per Sec. 339(G) *ensure that meal providers carry out such project with the advice of dietitians (or individuals with comparable expertise), meal participants, and other individuals knowledgeable with regard to the needs of older individuals*. Refer to NSI guidelines. Referral listings to intervention support within the community shall be made available. A 6+ score is a high risk for malnutrition. Complete a Level 1 Screen and per Sec. 339(1) *solicit the advice of a dietitian or individual with comparable expertise in the planning of nutritional service* or refer to the appropriate health care or social service professional in the planning and service area to follow up with ways to improve nutritional health."

Comprehensive delivery of available services in the community can help if someone has the responsibility to coordinate nutrition services.

Receiving Nutrition Services

- **Step #2.** In order to receive Home-Delivered Meals, an assessment of need is performed. Who should do the assessment and who should follow through with other needed services.

- **Step #3.** The Home-Delivered Meals assessment can be designed so that a volunteer or staff member with no particular educational qualifications can go to the home of the senior and provide the answers needed to determine if this person is homebound. There would be no questions on the Home-Delivered Meals assessment tool that would lead to diagnosing on the part of the assessor. However, this becomes an opportunity for comprehensive coordination if other services are found to be needed. Sec. 321(C)(22) If *case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in Section 306(a)(8).* Simply by providing a list of questions on the ADLs and IADLs would clearly demonstrate the need for other services or in accordance with Sec.321(a)(8) *services designed to provide health screening to detect or prevent illnesses, or both, that occur most frequently in older individuals*.

- **Step #4.** On the completion of the Home-Delivered Meals Assessment Tool, who shall be the qualifying person to complete the nutrition assessment follow-up in accordance with Sec. 321(a)(5)(A)(B)(C), *"services designed to assist older individuals in avoiding institutionalization and to assist individuals in long-term care institutions who are able to return to their communities, including (A) client assessment, case management services, and development and coordination of community services; (B) supportive activities to meet the special needs of caregivers, including caretakers who provide in-home services to frail older individuals; and (C) in-home services and other community services, including home health, homemaker, shopping, escort, reader, and letter writing services, to assist older individuals to live independently in a home environment."* It is important that this person be familiar with all home and community-based services in order to coordinate a plan of nutritional care. This definition should incorporate Sec. 302 (42 U.S.C. 3022)(1)(A)(B)(C) *"The term 'comprehensive and coordinated system' means a system for providing all necessary supportive services, including nutrition services, in a manner designed to (A) facilitate accessibility to, and utilization of, all supportive services and nutrition services provided within the geographic area served by such system by any public or private agency or organization; (B) develop and make the most efficient use of supportive services and nutrition services in meeting the needs of older individuals; (C) use available resources efficiently and with a minimum of duplication"* and Sec. 306 (42 U.S.C. 3026) Area Plans (2)(A) "*provide assurances that an adequate proportion, as required under section 307(a)(2) of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services: (A) services associated with access to services (transportation, outreach, information and assistance, and case management services)"*. Part of this supportive service may include a family caregiver who will

help, as per Sec. 321(a)(19) *"services designed to support family members and other persons providing voluntary care to older individuals that need long-term care services"* and specific to Sec. 373 (b)(1)(2)(3) *"Support Services: The services provided, in a State program under subsection (a), by an area agency on aging, or entity that such agency has contracted with, shall include: (1) information to caregivers about available services; (2) assistance to caregivers in gaining access to the services; (3) individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions and solving problems relating to their caregiving roles"*, or a neighbor, or someone from his or her place of worship. With instructions as per Sec. 321(17) *"health and nutrition education services, including information concerning prevention, diagnosis, treatment, and rehabilitation of age-related diseases and chronic disabling conditions"*, the senior may be able to learn how to prepare a breakfast meal or a simple dinner. USDA Extension Services can provide an agent to teach how to fix easy nutritious meals, or a Home Health Service can provide a homemaker.

<u>Promoting the relationship between nutrition, health, and functionality as well as health promotion/disease prevention calls for integrating the process of nutrition screening, assessment and care planning.</u>

Nutrition Case Management

Step #5. How can dietitians be seen as the appropriate professional to develop the responsibilities of the Nutrition Coordinator to make sure seniors are safe and secure and have their basic needs attended to as per Sec. 331(3) *"The Assistant Secretary shall carry out a program for making grants to States under State plans approved under section 307 for the establishment and operation of nutrition projects . . . (3) which may include nutrition education services and other appropriate nutrition services for older individuals"*, and Part D Sec.361 (42 U.S.C. 303m) (a),(b) *(a) The Assistant Secretary shall carry out a program for making grants to States under State plans approved under section 307 to provide disease prevention and health promotion services and information at multipurpose senior centers, at congregate meal sites, through home-delivered meals programs, or at other appropriate sites. In carrying out such program, the Assistant Secretary shall consult with the Directors of the Centers for Disease Control and Prevention and the National Institute on Aging. (b) The Assistant Secretary shall, to the extent possible, assure that services provided by other community organizations and agencies are used to carry out the provisions of this part."*, in providing defined services that are justified with outcome measures.

Step #6. The registered dietitian has a significant role in secondary and tertiary care in community-based programs to:

- ✓ prevent or decrease the frequency of malnutrition-related complications,
- ✓ improve or prevent deterioration in patient functionality by assuring an increasing trend in nutrient intake,
- ✓ halt or prevent weight loss as appropriate,

- ✓ address protein status within acceptable standards, and
- ✓ prescribe additional treatments that may be required to assure that underlying obstacles contributing to malnourished status are removed as possible.

State Aging Divisions and AAA's need to assure that the services are provided by the registered dietitian for nutrition programs consultation, to provide professional screens, to coordinate Nutrition Case Management, to perform nutrition counseling, and to administer medical nutrition therapy, and acknowledge that these kinds services are authorized service provisions under several funding sources including Part C and Part D. Medicare Waiver should specify the inclusion of the Registered Dietitian as part of the Home and Community-based Services Team in Case Management.

Following is an actual case of comprehensive coordination that took place in Vernal, Utah with the Ute Reservation, for the Elder Utes who were in need of Nutrition Case Management.

Observation was made that because several Elder Utes were left to be caretakers of their grandchildren, the home-delivered meals provided by Title VI were eaten mostly by the grandchildren, leaving no food for the Elders. This situation gave cause for concern by service providers for these Ute Elders.

1. The Title VI Nutrition Program Coordinator contacted the State Dietitian for technical assistance after a needs assessment screen, conducted by USU (Utah State University's Nutrition Department) as part of the AoA Senior Center Nutrition Program, confirmed the need for nutrition intervention.

2. A telephone conference call was held with the Title VI Nutrition Program Coordinator, the AAA Director of Uintah County Aging Services and the State Division of Aging's Dietitian, the local AAA's Consultant Dietitian and USU's Nutrition Staff. It was determined that several services needed to be delivered in order to assure quality nutrition intake for the Ute Elders. It was noted that the majority of the Ute Elders were also diabetic.

3. The AAA Director arranged through her RN Case Manager to go on-site the Ute Reservation to perform assessments of need for home-delivered meals and other services. Individual care plans, with quarterly reviews, were set up as an agreement requested by the Uintah AAA Director and granted by the Title VI Nutrition Coordinator. (This also allowed in-home observation of exploitation, neglect or abuse of the Elders. The results were a few cases where the elder parents were being financially exploited by their adult children. Their children would show up on the same day that the Ute Elders received their social security checks and the Elders would never see much of their money. In one particular case the Elder was afraid of his children. Referral was made to APS (Adult Protective Services).

4. Home-Delivered Meals were delivered by the Uintah AAA as a second meal to the Elders in need. (Another particular case, an Indian client is utilizing the Respite

Program as well as receiving second meals. The husband is taking care of a wife with Alzheimer's in advanced stages. The Uintah County AAA is coordinating services with the Indian Health Services, Medicare-funded home health as well as their AAA Respite program. While respite care is provided for a few hours per month in the home, the husband uses the time for respite to shop and take care of running errands. Uintah County AAA is delivering noon meals for the husband and wife; in addition, he receives noon meals from the Ute Tribe. He then is able to have their evening meal handled.)

5. Elders were also provided diabetes education by the Consultant Dietitian who is contracted with the Uintah AAA. This Consultant Dietitian, who works in an outpatient diabetes counseling program in a local hospital, is very familiar with the Ute Tribe. She was most successful in her diabetes education by emphasizing to the Elders the importance of taking care with proper food intake so they in turn could help their grandchildren's prevention of diabetes. (The Consultant Dietitian is also helping when clients on the reservation who are on dialysis need a special diet. She is spending time making telephone calls to them and working with the Title III cooks at the Uintah County AAA to modify the meals to meet the Elder Ute needs.)

6. USU-USDA Extension Services provided on-sight training to the Title VI cooks on native foods and plants that were available and would be appropriate for diabetics, so their meals would be more satisfying as well as meet the necessary food modifications for a diabetic diet.

7. The Ute Head Start Program was contacted to bring some of the children in for education and at the same time provide them a meal.

8. Commodities were delivered by the Title VI Program to help with the children's meals at home.

9. The nutrition intake, food security and health of the Elders improved.

10. All parties involved were pleased with the comprehensive coordination. No extra funding was required. It just took a team working together to provide needed services that were available. This is Nutrition Case Management, working together in the right direction.

<u>Summary</u>

The Nutrition Program for Seniors should promote and emphasize comprehensive preventive approaches which utilize community nutrition services to maintain the health and independence of older persons. The Nutrition Programs for Seniors should encourage the team of health and social services professionals serving older persons and their caregivers, when routinely evaluating the nutritional status of elderly persons to include

Nutrition Case Management in the support and services assessment care plan in order to maintain a person in his or her own home for as long as possible, and reduce further deterioration sooner by establishing a maintenance program, or promoting improvement, if at all possible.